Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS4635HPC	A. BUILDING B. WING 11/17/20		7/2010		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		.,
AFFINITY HOSPICE OF LIFE			2700 E SUI		ELDG D UNIT 36		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
L 000	L 000 INITIAL COMMENTS			L 000			
	This Statement of Deficiencies was generated as a result of a State Licensure Focused Survey conducted in your facility from November 15, 2010 through November 16, 2010, in accordance with Nevada Administrative Code, Chapter 449, Provision of Hospice Care. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.						
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.						
	Fourteen patient files Seventeen employee						
	The following regulate identified:	ory deficiencies were					
L9999	FINAL OBSERVATION	DNS		L9999			
	a medical facility or a shall have a: (a) Physical examina licensed physician that good health, is free fr	ment, a person employed facility for the dependent ation or certification from at the person is in a state of active tuberculosis able disease in a contaguitin skin test, including	ent n a te of and				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBI		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS4635HPC		B. WING		11/17/2010	
NAME OF PR	ROVIDER OR SUPPLIER	NVO-1000III G	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	11/1//2010	
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	persons with a history of bacillus Calmette-Guerin (BCG) vaccination.						
	If the employee has no documented history of a 2-step Mantoux tuberculin skin test and has not had a single Mantoux tuberculin skin test within the preceding 12 months, then a 2-step Mantoux tuberculin skin test must be administered. A single annual Mantoux tuberculin skin test must be administered thereafter. NAC 441A.375(4) An employee with a documented history of a positive Mantoux tuberculin skin test is exempt from screening with skin test or chest radiographs unless he develops symptoms suggestive of tuberculosis. NAC 441A.375(6) Counseling and preventive therapy must be offered to a person with a positive Mantoux tuberculin skin test in accordance with the recommendations of the American Thoracic Society and the American Lung Association set forth in "Tuberculosis: What the Physician Should Know."						
			set				
	NAC 441A.380(2)						
	staff of a facility for the facility for extended continuous for extended for	provided in this section, e dependent or a medicare, skilled nursing, or all: Iter a person, including of bacillus Calmette-Guadmitted to the facility, in has a Mantoux tuberd is not a person qualificathe facility when the pe	a uerin culin ed to				

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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	Control for preventing tuberculosis in faciliti forth in "Guidelines Transmission of Tube Settings, with Special Issues." 2. A medical facil dependent shall main	the Centers for Disease g the transmission of es providing health care for Preventing the erculosis in Health-Care I Focus on HIV-Related ity or facility for the ntain surveillance of ility for tuberculosis and	e set				

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 forth in " Tuberculosis: What the Physician Should Know." 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculin skin test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92) NAC 441A.380 Admission of persons to medical facility for extended care, skilled nursing, or intermediate care or facility for the dependent: Testing; respiratory isolation; medical treatment; counseling and preventive therapy; documentation. 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing, or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent or a medical facility for extended care, skilled nursing, or intermediate care shall: (a) Before admitting a person to the facility, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum;		ry of shall alist, large as not nen oms lall lalist. It is a shall				

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